9STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

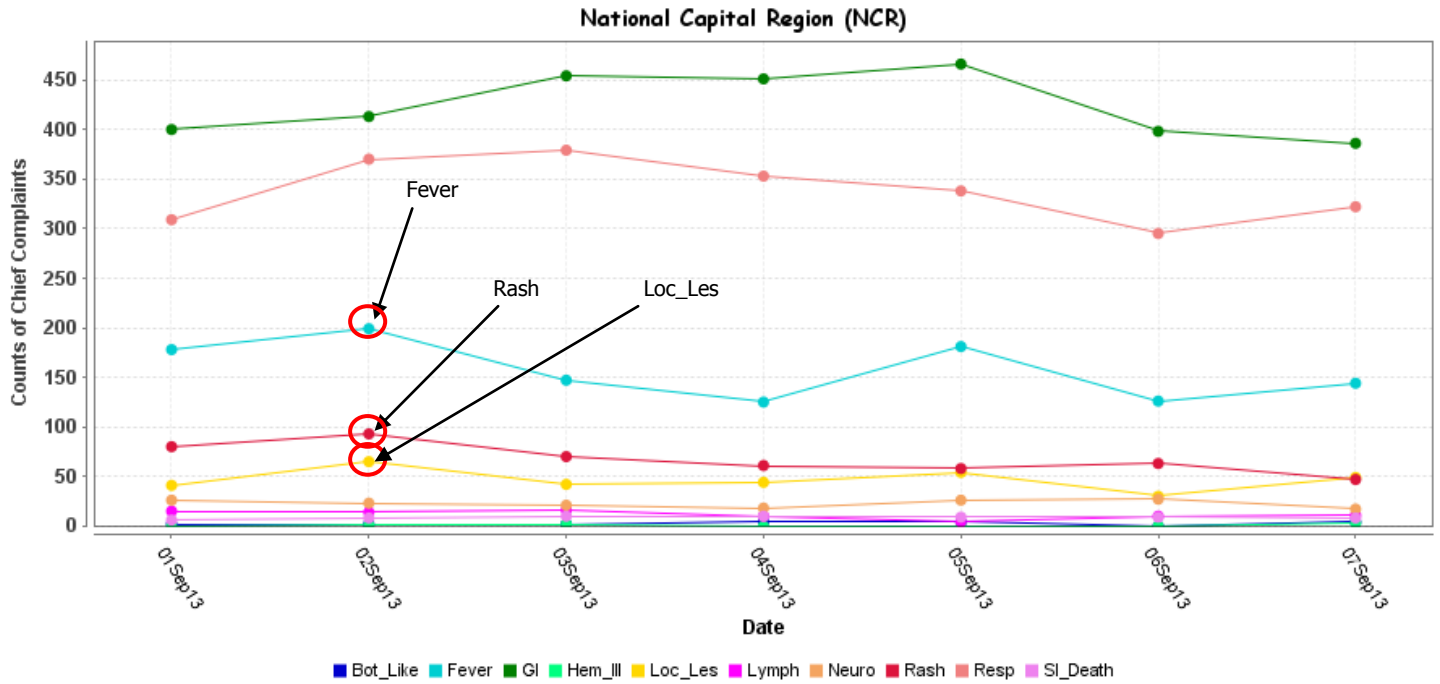
# September 13, 2013

# Public Health & Emergency Preparedness Bulletin: # 2013:36
# Reporting for the week ending 09/07/13 (MMWR Week #36)

**CURRENT HOMELAND SECURITY THREAT LEVELS**

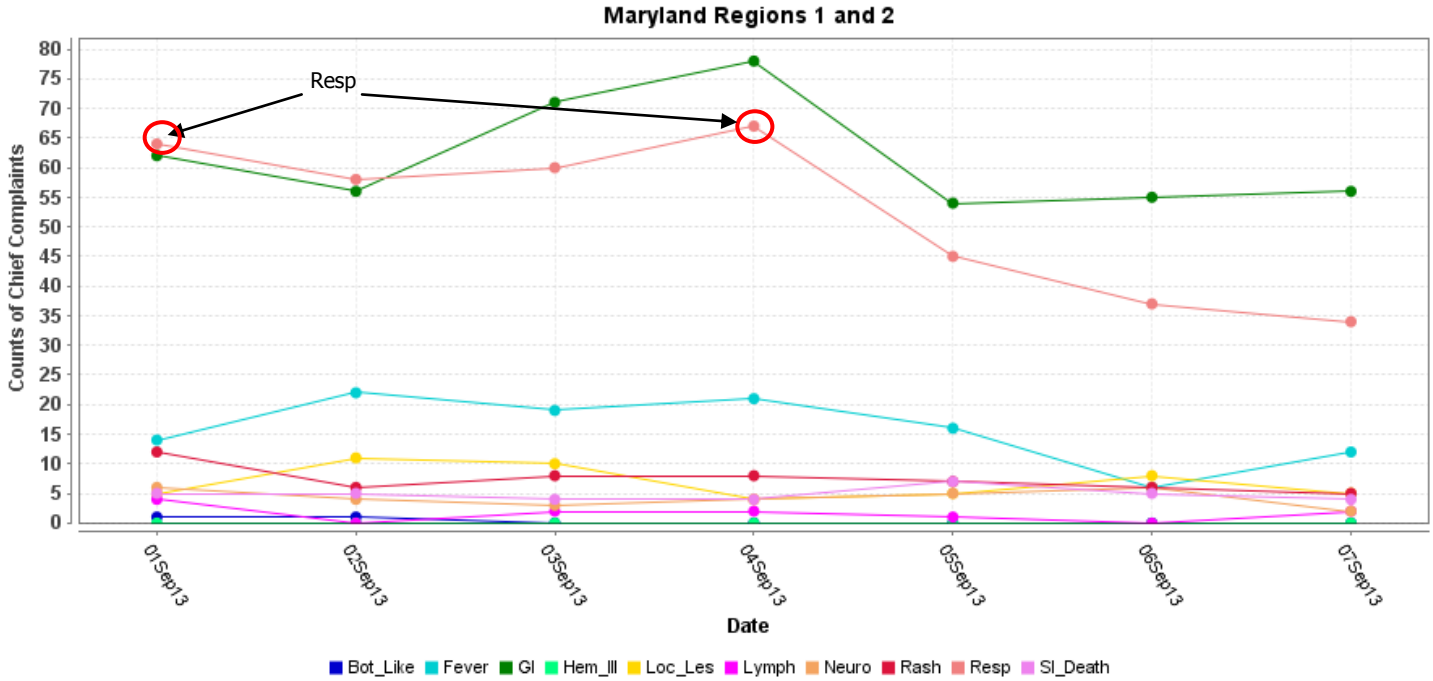
**National:** **No Active Alerts**
**Maryland:** **Level Four (MEMA status)**

**SYNDROMIC SURVEILLANCE REPORTS**
**ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics):**
Graphical representation is provided for all syndromes, excluding the "Other" category, all age groups, and red alerts are circled. Red alerts are generated when observed count for a syndrome exceeds the 99% confidence interval. Note: ESSENCE – ANCR uses syndrome categories consistent with CDC definitions.
Overall, no suspicious patterns of illness were identified. Track backs to the health care facilities yielded no suspicious patterns of illness.

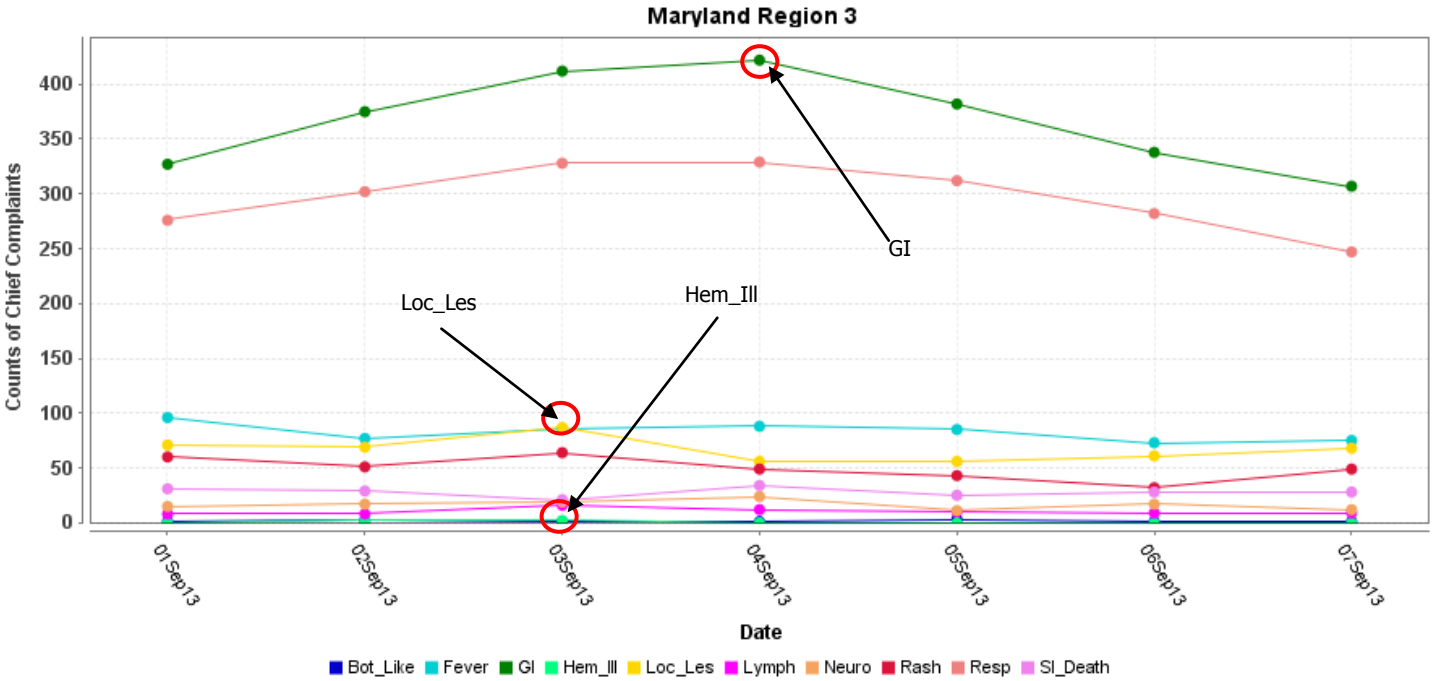


*Includes EDs in all jurisdictions in the NCR (MD, VA, and DC) reporting to ESSENCE

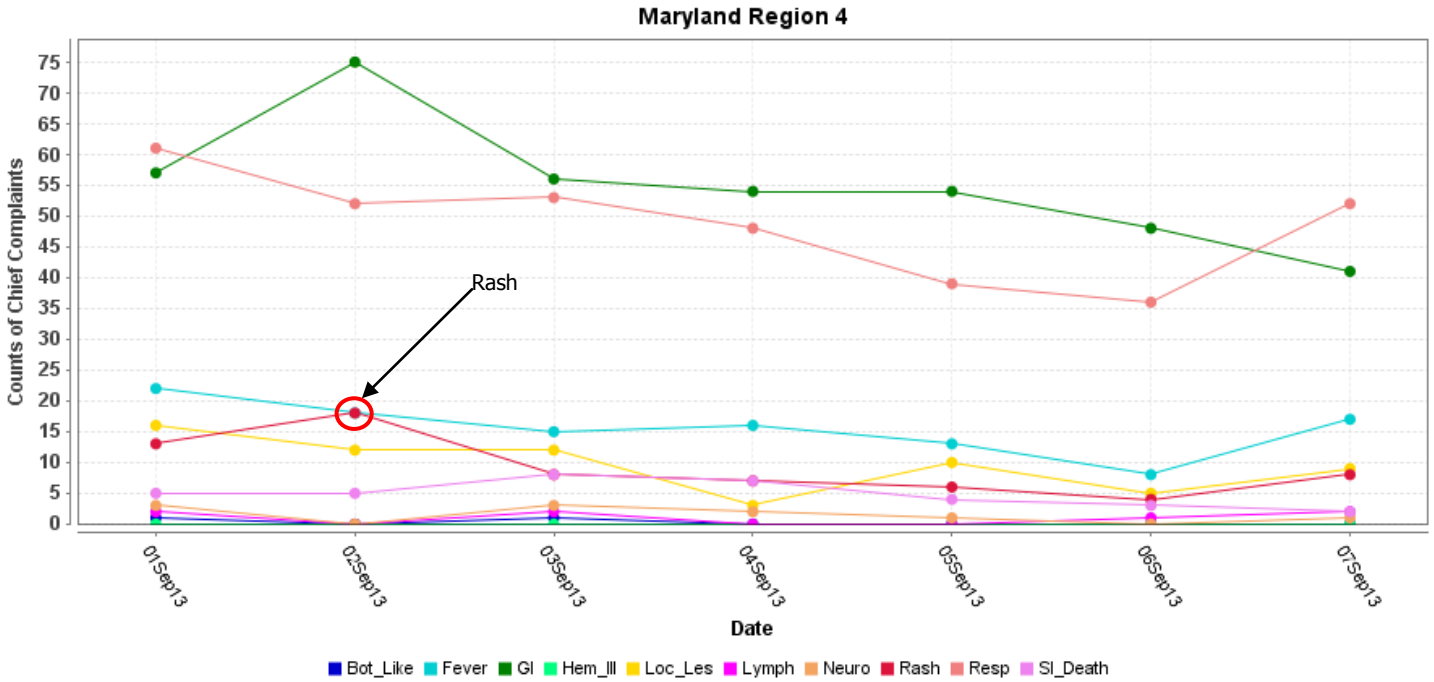
**MARYLAND ESSENCE:**



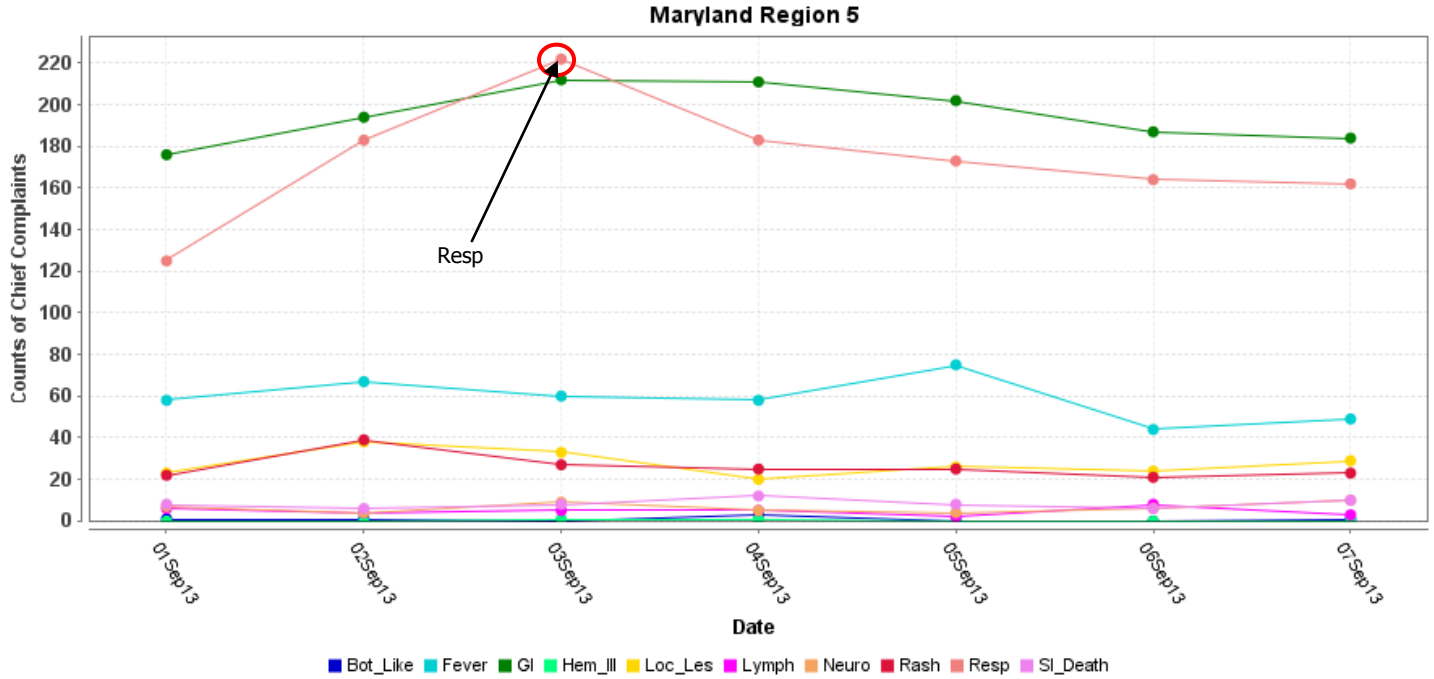

* Region 1 and 2 includes EDs in Allegany, Frederick, Garrett, and Washington counties reporting to ESSENCE




* Region 3 includes EDs in Anne Arundel, Baltimore City, Baltimore, Carroll, Harford, and Howard counties reporting to ESSENCE



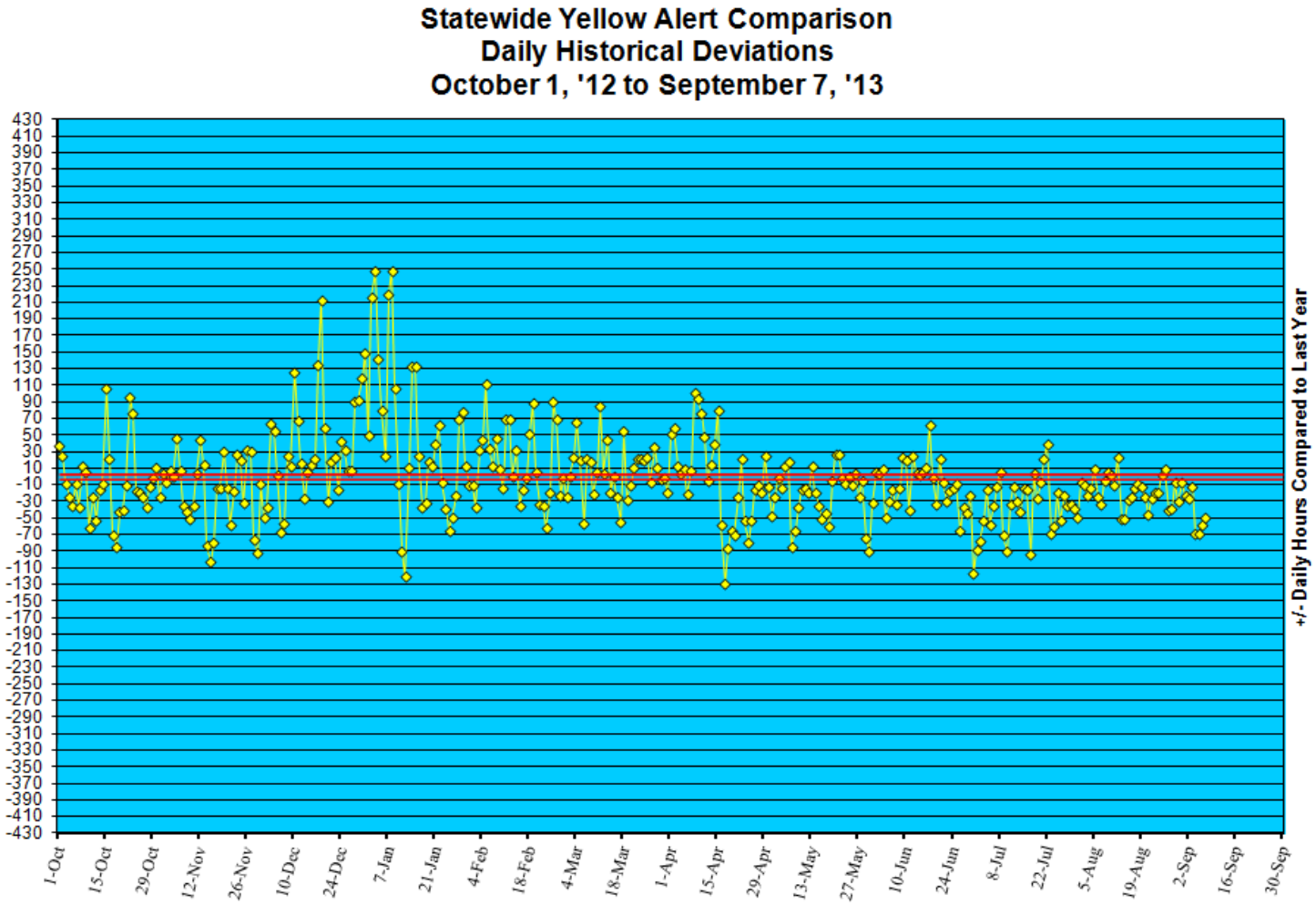

* Region 4 includes EDs in Cecil, Dorchester, Kent, Somerset, Talbot, Wicomico, and Worcester counties reporting to ESSENCE




* Region 5 includes EDs in Calvert, Charles, Montgomery, Prince George's, and St. Mary's counties reporting to ESSENCE

**REVIEW OF EMERGENCY DEPARTMENT UTILIZATION**

**YELLOW ALERT TIMES (ED DIVERSION):** The reporting period begins 10/01/11.




**REVIEW OF MORTALITY REPORTS**

**Office of the Chief Medical Examiner:** OCME reports no suspicious deaths related to an emerging public health threat for the week.

**MARYLAND TOXIDROMIC SURVEILLANCE**

**Poison Control Surveillance Monthly Update:** Investigations of the outliers and alerts observed by the Maryland Poison Center and National Capital Poison Center in August 2013 did not identify any cases of possible public health threats.

## REVIEW OF MARYLAND DISEASE SURVEILLANCE FINDINGS

**COMMUNICABLE DISEASE SURVEILLANCE CASE REPORTS (confirmed, probable and suspect):**

| **Meningitis:** | **Aseptic** | **Meningococcal** |
|---|---|---|
| New cases (September 1 - September 7, 2013): | 9 | 0 |
| Prior week (August 25 - August 31, 2013): | 4 | 0 |
| Week#36, 2012 (September 3 – September 9, 2012): | 6 | 0 |

**2 outbreaks were reported to DHMH during MMWR Week 35 (August 25 – August 31, 2013)**

1 Foodborne Outbreak
1 outbreak of SCOMBROID POISONING associated with a Restaurant

1 Respiratory Illness Outbreak
1 outbreak of PNEUMONIA in a Nursing Home

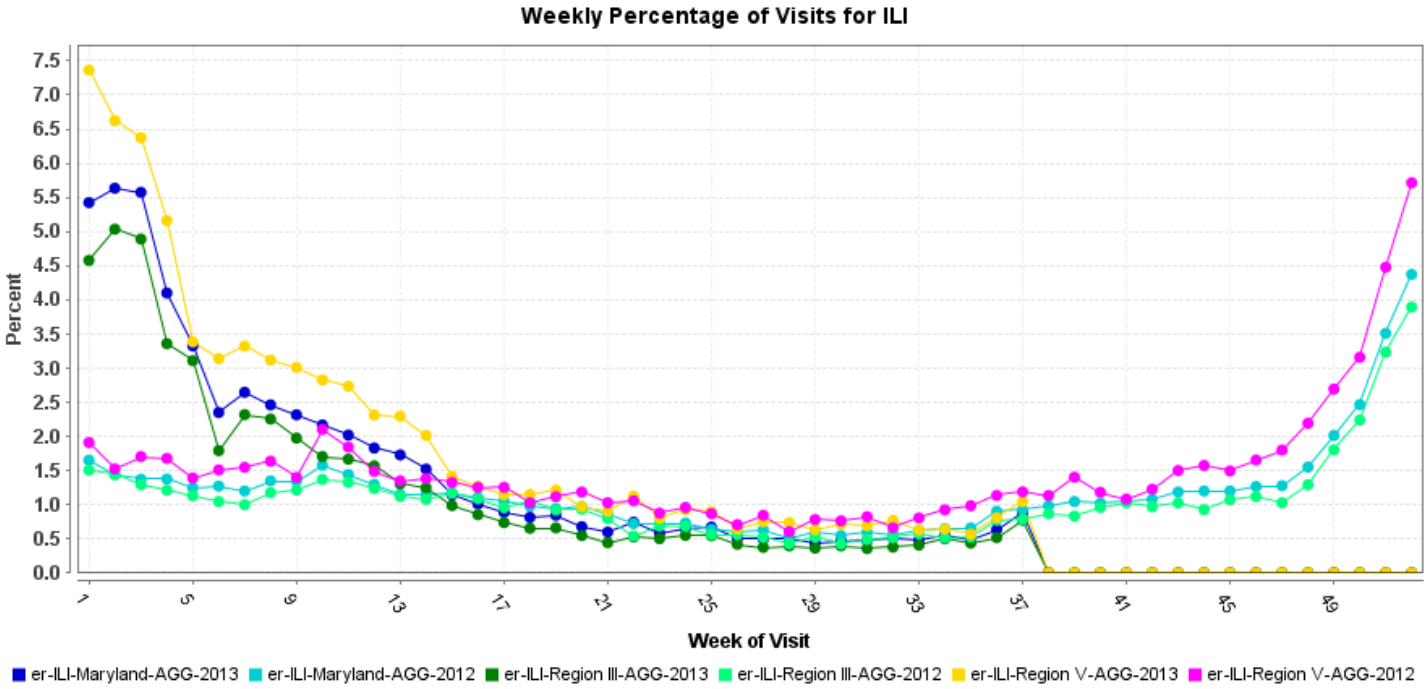
## MARYLAND SEASONAL FLU STATUS

Seasonal Influenza reporting occurs October through May.

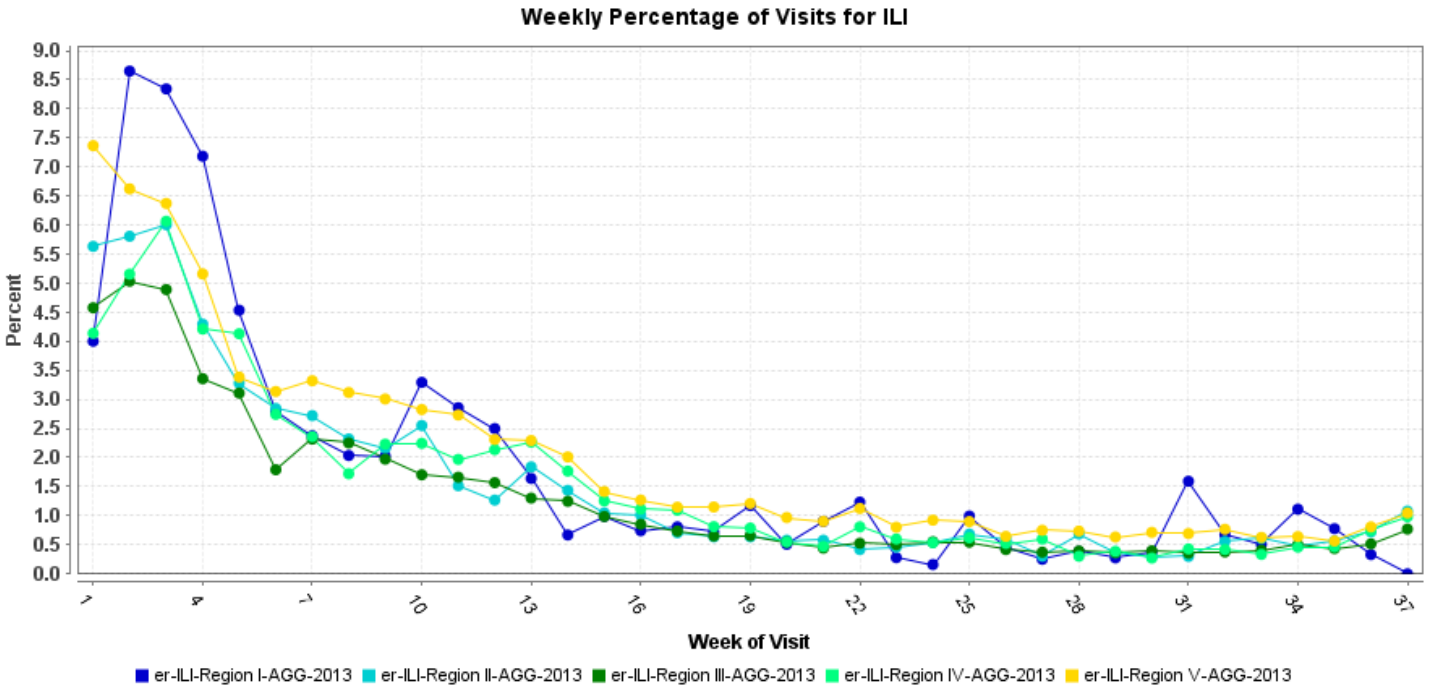
## SYNDROMIC SURVEILLANCE FOR INFLUENZA-LIKE ILLNESS

Graphs show the percentage of total weekly Emergency Department patient chief complaints that have one or more ICD9 codes representing provider diagnoses of influenza-like illness. These graphs do not represent confirmed influenza.

Graphs show proportion of total weekly cases seen in a particular syndrome/subsyndrome over the total number of cases seen. Weeks run Sunday through Saturday and the last week shown may be artificially high or low depending on how much data is available for the week.



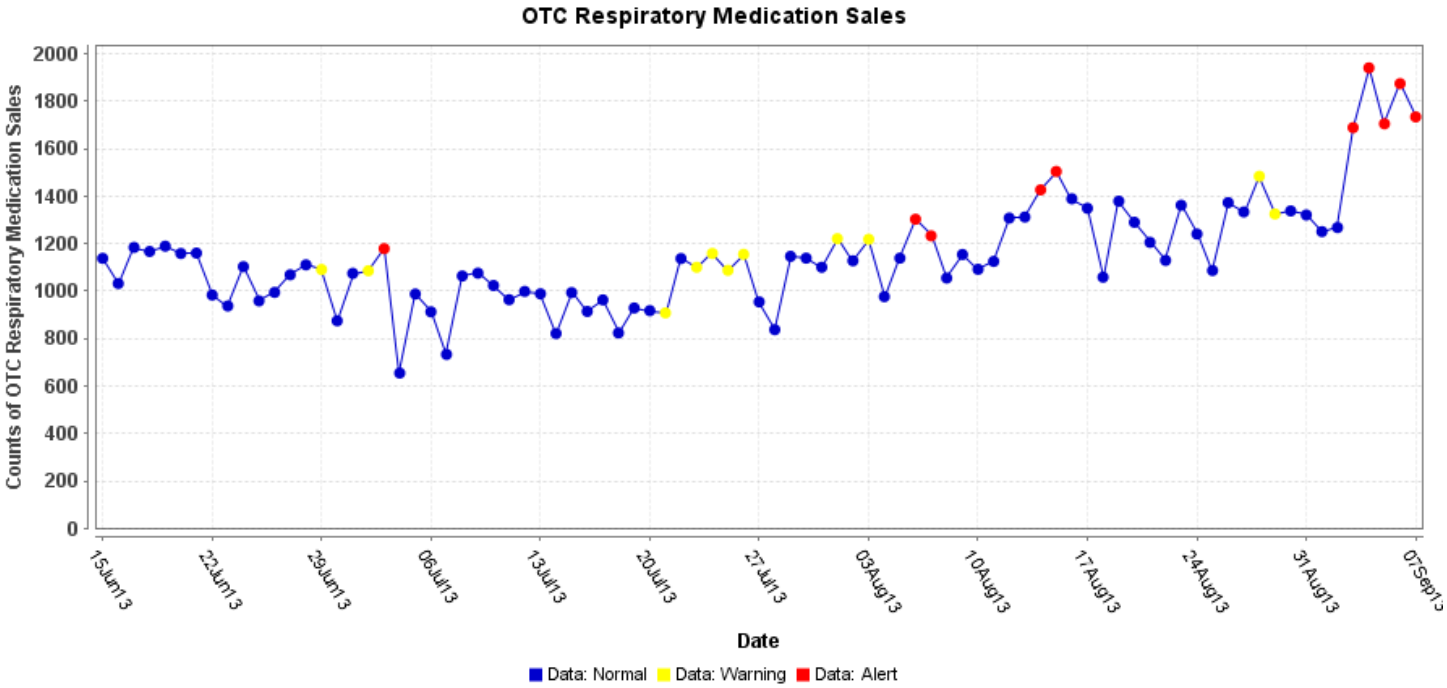

* Includes 2012 and 2013 Maryland ED visits for ILI in Metro Baltimore (Region 3), Maryland NCR (Region 5), and Maryland Total




*Includes 2013 Maryland ED visits for ILI in Region 1, 2, 3, 4, and 5

**OVER-THE-COUNTER (OTC) SALES FOR RESPIRATORY MEDICATIONS:**

Graph shows the daily number of over-the-counter respiratory medication sales in Maryland at a large pharmacy chain.



**PANDEMIC INFLUENZA UPDATE / AVIAN INFLUENZA-RELATED REPORTS**

**WHO update:** The current WHO phase of pandemic alert for avian influenza is ALERT. Currently, the avian influenza H5N1 virus continues to circulate in poultry in some countries, especially in Asia and northeast Africa. This virus continues to cause sporadic human infections with some instances of limited human-to-human transmission among very close contacts. There has been no sustained human-to-human or community-level transmission identified thus far.

Influenza A (H7N9) is one of a subgroup of influenza viruses that normally circulate among birds. Until recently, this virus had not been seen in people. However, human infections have now been detected. As yet, there is limited information about the scope of the disease the virus causes and about the source of exposure. The disease is of concern because most patients have been severely ill. There is no indication thus far that it can be transmitted between people, but both animal-to-human and human-to-human routes of transmission are being actively investigated.

**Alert phase**: This is the phase when influenza caused by a new subtype has been identified in humans. Increased vigilance and careful risk assessment, at local, national and global levels, are characteristic of this phase. If the risk assessments indicate that the new virus is not developing into a pandemic strain, a de-escalation of activities towards those in the interpandemic phase may occur. As of August 29, 2013, the WHO-confirmed global total of human cases of H5N1 avian influenza virus infection stands at 637, of which 378 have been fatal. Thus, the case fatality rate for human H5N1 is approximately 59%.

**AVIAN INFLUENZA, HUMAN, H5N1 (CAMBODIA):** 04 September 2013, A 15-month-old boy in the capital's [Phnom Penh's] Russei Keo district has been diagnosed with H5N1 virus, bringing the number of the cases to 18 so far this year [2013], a joint statement by the World Health Organization and Cambodian Health Ministry said Wednesday [4 Sep 2013]. The boy was confirmed positive for human H5N1 avian influenza last Friday [30 Aug 2013] after he was admitted to the Kantha Bopha Hospital with fever, cough, diarrhea, sneezing, lethargy and dyspnea, the statement said. "The boy was treated with Tamiflu, and he is in stable condition," it said. "Investigations are being carried out by the Ministry of Health in the boy's village in order to determine whether the child came into contact with sick or dead poultry," the statement said. Only 8 cases out of the 18 cases this year [2013] survived. The latest death case was a 9-year-old boy from northwestern Battambang province, who died last month [August 2013]. Avian influenza H5N1 remains a serious threat to the health of all Cambodians, Health Minister Mam Bunheng said. "Children seem to be most vulnerable and are at high risk because they like to play where poultry are found," he said in the statement. "I urge parents and guardians to keep children away from sick or dead poultry and make sure children wash their hands with soap and water after any contact with poultry." Cambodia sees the worst outbreak of the virus this year [2013] since the disease was 1st identified in 2004. To date, the country has recorded 39 human cases of the virus, killing 29 people.

**AVIAN INFLUENZA, HUMAN, H7N7 (ITALY):** 02 September 2013, The National Institute of Health had recorded a positive [diagnosis] for H7N7 avian influenza virus in a person suffering from conjunctivitis and occupationally exposed to sick birds belonging to the farms in the region of Emilia Romagna,where this viral infection is prevalent. The H7N7 avian influenza virus is not easily transmitted to humans, who can become infected only if there is direct contact with a sick or dead animal. Unlike other avian viruses (such as H7N9 or H5N1), avian H7N7 influenza virus tends to result only in man a mild disease (such as conjunctivitis), as has been observed previously in a human outbreak that occurred years ago in the Netherlands. Since transmission from person-to-person is rare, human outbreaks tend to self-contained, so the risk to the community is extremely low or even non-existent. The Emilia Romagna Region authorities, in cooperation with the Ministry of Health, have already identified outbreaks in poultry, and appropriate measures have been taken to control the outbreak.

**NATIONAL DISEASE REPORTS***

**CYCLOSPORIASIS (USA):** 06 September 2013, The nationwide cyclospora outbreak has now sickened 641 people and hospitalized 41, according to the latest update by the CDC. That's an increase of 5 since the last update last week, which indicates the outbreak may be slowing down. No deaths have been reported. The number of cases in each area is as follows: Texas (282), Iowa (156), Nebraska (86), Florida (32), Wisconsin (16), Illinois (11), Arkansas (10), Georgia (5), Missouri (5), New York City (5), Kansas (4), Louisiana (3), Connecticut (2), Michigan (1), Minnesota (2), New Jersey (4), New York (2), Ohio (2), Virginia (3), California (1), New Hampshire (1), South Dakota (1), Tennessee (1), and Wyoming (1). The patient age range remains from less than one year to 92 years, with a median age of 51 years; 56 percent of infected persons are female. The case count includes anyone who became ill before 28 Jul 2013. The cases in Iowa and Nebraska are linked to a salad mix produced by Taylor Farms de Mexico and served at Red Lobster and Olive Garden restaurants. The case count in Texas, which is the highest in the country, may not be connected to Taylor Farms de Mexico, and all cases are not necessarily related to each other. The CDC recommends that consumers eat fresh fruits and vegetables, but wash them thoroughly before preparing and eating, and follow safe produce handling recommendations. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

**TULAREMIA (MASSACHUSETTS):** 05 September 2013. A total of 4 island residents have been diagnosed with the infectious disease tularemia, commonly known as rabbit fever, according to the Nantucket Health Department. Town officials are urging island residents to avoid touching dead rabbits or other small animals, or approaching any animal that appears to be disoriented or sluggish. The Health Department is also advising landscapers to wear respirator masks when cutting grass over 6 inches tall to reduce the risk of exposure in the event a hidden animal is struck and the bacterium can become aerosolized. Tularemia, caused by the bacterium Francisella tularensis, can be transmitted to humans who handle sick or deceased animals or are bitten by infected ticks or deer flies, according to the CDC. It can also be transmitted by inhaling contaminated dusts or aerosols. The disease, which can cause fever, skin ulcers, and pneumonia, and is potentially life-threatening in rare cases, is most often treated and controlled successfully with antibiotics. "We need the public to be aware," Nantucket Health Department director Richard Ray said. "If there's a dead animal near the side of the road, ignore it, do not let your animal go near it, and call the DPW [Department of Public Works] to remove it. Please be careful about where your lawnmower goes and what it runs over. We've had a few cases over the years, but not 4 at one time." (Tularemia listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

**INTERNATIONAL DISEASE REPORTS***

**ANTHRAX (BANGLADESH):** 07 September 2013, Anthrax continues to scourge people mostly in the south-western Meherpur [district, Khulna division] and northern Sirajgang district [Rajshahi division]. In its latest bout, at least 7 people, including 4 women and a 10-year-old, have been confirmed to have been infected with the bacterium [Bacillus anthracis] in a village of Sirajganj's Shahjadpur upazilla. The bacterium remains a perennial problem in Bangladesh. In 2010 it took a heavy toll on Bangladesh's export-oriented leather industry. Director of the government's disease monitoring arm, IEDCR [Institute of Epidemiology, Disease Control and Research], Professor Mahmudur Rahman, told bdnews24.com they had confirmation of 7 new patients identified on Wednesday [4 Sep 2013] and Thursday [5 Sep 2013]. They were under treatment, he said. bdnews24.com Sirajganj correspondent, quoting livestock officials, said a diseased cow had been slaughtered and those infected were engaged with processing and cleaning. The bacterium can survive in the soil in harsh conditions for even centuries. Cattles get infected while grazing during rainy days when water brings the bacterium to the surface. It only passes on to the human while handling infected livestock, though not life-threatening. Person-to-person transmission does not occur but it can be fatal if it goes into lungs and intestines. The IEDCR strongly recommends "not to slaughter sick cattle". A cheap vaccine can keep animals healthy from the bacterium, but it is reported that the vaccination is not being carried out properly across the country. Shahjadpur Upazilla Livestock Officer Dr Abdul Hai said in March [2013] they had vaccinated all cattle of the 'Charkoijuri' village from where those people were found infected. "The infected cow might have been imported from other place," he said. The IEDCR Director said people should know how to dispose of dead animals. "They usually throw dead animals either into the water bodies or in the open field that helps the bacterium to stay on the surface". He urged all to bury dead animals after wrapping them with plastic. So far, more than 240 cases have been confirmed this year [2013]. Of them, 141 were only from Gangni of Meherpur. With the latest cases, the number rose to 26 at Shahjadpur. In 2010, the number crossed 600 across Bangladesh, leading people to stop buying meat and triggering a downturn in meat sales. Even the government declared a red alert on livestock officials during Eid holidays. The IEDCR 1st recorded anthrax in 1986 among 19 tannery workers. Pabna, Kushtia, Tangail, Manikganj, Satkhira, Lalmonirhat, Rajshahi, Narayanganj, Laxmipur, and some parts of Chittagong are the other districts where anthrax patients are usually found. (Anthrax listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

**LEPTOSPIROSIS (PHILIPPINES):** 07 September 2013, An "alarming" 33 cases of leptospirosis, 7 of them fatal, were noted this past week at the Philippine General Hospital [PGH], the University of the Philippines [UP] Manila said Friday [6 Sep 2013]. UP Manila said Dr. Kristin Luzentales, PGH Chief Fellow of Section of Adult Nephrology, said 33 cases were admitted since [31 Aug 2013]. "The Section of Nephrology of Department of Medicine at the UP PGH has reported an alarming increased rate of admissions from leptospirosis," it said. This was shortly after floods and rain from the southwest monsoon enhanced by Tropical Storm Maring swamped Metro Manila and nearby areas in Luzon. UP Manila noted 680 leptospirosis cases, 40 of them fatal, occur on average every year. Citing information from the Philippine Clinical Practice Guidelines in 2010, it said leptospirosis is "seasonal with a peak incidence during the rainy months of July to October." PGH nephrologist Dr. Rey Tan said signs of leptospirosis may include: acute febrile illness of at least 2 days and either residing in a flooded area or has high-risk exposure; at least 2 of the following symptoms: myalgia, calf tenderness, conjunctival suffusion, chills, abdominal pain, headache, jaundice, or oliguria. High-risk exposure involves wading in floods and contaminated water, contact with animal fluids, swimming in floodwater or ingestion of contaminated water with or without cuts or wounds. "Clinicians should therefore have a high index of suspicion among patients with febrile illness and high risk exposures because mortality may be as high as 15 percent," Tan said. He advised patients with fever, muscle pain and headache to consult their doctors immediately. Tan warned of potentially fatal complications like kidney failure that will need urgent dialysis. (Water Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

**MERS-COV (SAUDI ARABIA):** 06 September 2013, As an update on cases of MERS-COV in KSA [Kingdom of Saudi Arabia], the MOH [Ministry of Health] released the report on 4 new cases yesterday [5 Sep 2013]:
- A 41-year-old female health care worker from Riyadh with no comorbidities with onset of symptoms on [15 Aug 2013] with cough and fever. Developed severe pneumonia requiring intubation and ventilation in critical care unit. There was no history of contacts with animals or a positive case. Patient condition deteriorated and she passed away. Investigation of source is still ongoing.
- A 30-year-old Saudi male health care worker from Riyadh who is a contact of a positive case, and who developed severe pneumonia and intubated [4 Sep 2013]. The patient is currently in critical condition.
- A 79-year-old Saudi female from Hafr Albatin province, a contact of a positive case from [21 Aug 2013]. Presented with respiratory symptoms and her condition deteriorated and passed away [2 Sep 2013].
- A 47-year-old Saudi male from Hafr Albatin province, a contact of a positive case, with onset of symptoms [23 Aug 2013]. Patient condition deteriorated, requiring critical care, and he is still under treatment in critical condition.

Detailed investigation of all cases is ongoing.
(Emerging infectious diseases are listed in Category C on the CDC List of Critical Biological Agents) *Non-suspect case

**LASSA FEVER (SIERRA LEONE):** 06 September 2013, A report reaching Concord Times indicated that a number of staff of Medicine San Frontiers (MSF) have allegedly died of Lassa fever in the municipality of Bo [Southern Province]. The report stated that a nurse, driver and a community health officer, alongside her 2 children, lost their lives after being allegedly infected with the disease; a situation which has left some section of the Bo population worried. MSF's project coordinator in Bo, John Mark, told Concord Times in an interview that they were doing all they could to curb the infection and death rate among their staff. "It is really difficult to ascertain whether it is our staff or patients brought to the referral clinic that are responsible for this dreadful disease," Mark said. "Suspected Lassa fever patients' blood specimens are usually taken to the Kenema government hospital Lassa department for testing, and if proven positive or infected, they (staff) will be transferred to Kenema for treatment." He maintained that their nurses at the Gondama clinic use preventive measures and gear to keep themselves free from the Lassa fever disease and any other dreadful disease(s). (Viral Hemorrhagic Fevers are listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

**ANTHRAX (KYRGYZSTAN):** 05 September 2013, Another anthrax case was registered in Kyrgyzstan, Public Health Department under the Health Care Ministry of Kyrgyzstan informed 24.kg news agency. According to its data, a 33-year-old resident of Bakay-Ata district, Talas province, was diagnosed with anthrax on 3 Sep [2013]. He was hospitalized with suspected disease and was tested. The diagnosis was confirmed [4 Sep 2013]. As it was being reported, his 31-year-old fellow villager was also taken to hospital with the symptoms of the disease. It was noted that this was not the 1st case. During the previous month [August 2013], a resident of Alamudun district, Chui province, was also diagnosed with anthrax. (Anthrax listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

**FOODBORNE ILLNESS (CANADA):** 05 September 2013, New lab results suggest inadequate refrigeration caused the outbreak of foodborne illness at the CNE [Canadian National Exhibition] linked to a Toronto bakery's maple bacon jam topping for the cronut burger, says Toronto Public Health [TPH]. Le Dolci, which supplied both the cronut bun and jam for the burger, has been allowed to reopen, but with conditions including additional food safety training, and supervised cleaning and sanitation. "Our investigation suggests that inadequate refrigeration of the maple bacon jam at multiple points before serving to the customer (both at the Le Dolci preparation site and Epic Burgers and Waffles) would have allowed the [staphylococcal] bacteria to grow and produce the [entero]toxin that led to illness," TPH spokeswoman Kris Scheuer said in an email. While the brown sugar and maple syrup results came back negative, the bacon tested positive, but for different bacteria. The bacterial toxin found in jam samples from both Le Dolci and Epic Burgers was actually produced from a different strain of Staphylococcus aureus than that found in the bacon. "So the bacon is not to 'blame,'" Scheuer said. By Wednesday morning, 4 Sep 2013, TPH had interviewed 250 people complaining of symptoms of foodborne illness after eating at the CNE. "At least 90 people who ate at Epic Burgers and Waffles between 16 and 20 Aug 2013 reported having specific symptoms consistent with S. aureus food poisoning. Of those 90 people, 87 ate the cronut burger," said Scheuer. Le Dolci closed voluntarily in the wake of the investigation. The bakery is not allowed to produce maple bacon jam for the time being, but could make it again in the future with TPH's approval of ingredient sources and tweaks to the production process. TPH will continue to monitor Le Dolci "to ensure adherence with the specified conditions and other food safety requirements," said Scheuer. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

**JAPANESE ENCEPHALITIS (CHINA):** 05 September 2013, The Centre for Health Protection (CHP) of the [Hong Kong] Department of Health (DH) is today (4 Sep 2013) investigating an imported case of Japanese encephalitis (JE) [virus infection] affecting a 20-year-old man, and hence urged the public to take precautions against mosquito-transmitted diseases. The patient, with good past health, developed fever and vomiting on 24 Aug [2013] in Thailand and subsequently consulted a local doctor on 26 Aug [2013]. Upon arrival in Hong Kong on 31 Aug [2013], he sought medical attention from Princess Margaret Hospital, where he is currently admitted for management in stable condition. Both his serum and cerebrospinal fluid samples tested positive for antibodies against JE [virus], a viral disease transmitted by the bite of infective mosquitoes, upon preliminary laboratory testing by the Public Health Laboratory Services Branch of the CHP. Initial enquiries by the CHP revealed that the patient had travelled to Thailand from 28 Jul to 31 Aug [2013]. The CHP's investigation is proceeding. To date, 3 JE cases (2 local and one imported) have been reported to the CHP this year. In 2012, 3 cases (2 imported and one local) were reported while one (a local case) was reported in 2011. Locally, no cases were reported from 2008 to 2010. A CHP spokesman explained that JE is a viral disease transmitted by the bite of infected mosquitoes. Culex tritaeniorhynchus (Culicine mosquito) is the principal vector of JE and is nocturnal. It mainly breeds in waterlogged fields, marshes, ditches and small stagnant collections of water around cultivated fields. The mosquitoes become infected by feeding on pigs [amplifying host] and wild birds [reservoir host] infected with the JE virus, and then transmit the virus to humans and animals during the feeding process. JE [virus] is endemic in the Mainland and Southeast Asia. Most JE virus infections are mild without apparent symptoms other than fever with headache. More severe infections are clinically characterised by quick onset of headache, high fever, neck stiffness, impaired mental state, coma, tremors, occasional convulsions (especially in infants) and paralysis. To prevent contracting JE, members of the public, particularly those living in rural areas, are reminded to take heed of the following preventive measures, especially after dark:
- Wear long-sleeved clothes and trousers;
- Use effective insect repellents containing DEET over exposed parts of the body when outdoors; and
- Use mosquito screens or nets in rooms which are not air-conditioned.
Travellers to endemic areas of JE should take the following precautions:
- Avoid outdoor exposure to mosquito bites at dusk and dawn, especially in rural areas, when mosquitoes spreading this virus are most active;
- Apply effective insect repellents containing DEET over exposed parts of the body and clothes; and
- Consider vaccination that should be completed at least 10 days before departure to endemic areas in Asia or the Western Pacific for staying over one month, particularly in high-risk rural areas. (Viral Encephalitis is listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

**E. COLI EHEC (AUSTRALIA):** 03 September 2013, Queensland Health is continuing to investigate an outbreak of an enterohemorrhagic Shiga toxin-producing E. coli (EHEC) in Brisbane. So far, 32 people are confirmed to have EHEC, and a further 103 samples are being tested for the infection from people who may potentially have the infection. Five people have been hospitalized and have since been discharged. Acting Senior Director Communicable Diseases Unit Dr. Stephen Lambert said there had been a significant response to the outbreak, which has led to a large number of people undergoing testing for the infection. "The community's response has been great. People have been listening and seeking medical treatment if they have symptoms," Dr. Lambert said. This, combined with the medical community's response, has meant that a significant number of cases of gastroenteritis are under investigation. "I thank everyone for their response to this important public health issue to assist in preventing any further outbreak." For those scientific types interested in this issue, E. .coli O157 is the specific strain that caused this outbreak. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

**HANTAVIRUS (ARGENTINA):** 03 September 2013, A young man from Magdelena is currently interned in a La Plata hospital with a clinical picture of a hantavirus infection. This young man was taken recently from his hometown to the Hospital Espanol in our city [La Plata]. This situation unleashed the fury of his family members and friends, who blocked Route 11 for various hours in "repudiation of the attention that he had in the Magdalena health center," said the father of the young man. This past 26 Sep [2013], the young man was diagnosed with a hantavirus infection from laboratory tests done in the Malbranl Hospital, a reference institution for the study and treatment of this type of disease. Some 10 days before, he suffered symptoms compatible with severe influenza or angina and was attended to in the Santa Maria Magdalena Municipal Hospital, where, as his father stated, he was diagnosed with "gastroenteritis." The father decided to take his son out of the local hospital and take him on his own to Espanol Hospital in La Plata, "where he received a better type of attention." In the hospital at the corner of streets 9 and 35, he received intensive care and is stable with slight improvement, according to sources from this health center. (Emerging infectious diseases are listed in Category C on the CDC List of Critical Biological Agents) *Non-suspect case

*National and International Disease Reports are retrieved from http://www.promedmail.org/.

**OTHER RESOURCES AND ARTICLES OF INTEREST**

More information concerning Public Health and Emergency Preparedness can be found at the Office of Preparedness and Response website: http://preparedness.dhmh.maryland.gov/

Maryland's Resident Influenza Tracking System: http://dhmh.maryland.gov/flusurvey

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**NOTE**: This weekly review is a compilation of data from various surveillance systems, interpreted with a focus on a potential BT event. It is not meant to be inclusive of all epidemiology data available, nor is it meant to imply that every activity reported is a definitive BT event. International reports of outbreaks due to organisms on the CDC Critical Biological Agent list will also be reported. While not "secure", please handle this information in a professional manner. Please feel free to distribute within your organization, as you feel appropriate, to other professional staff involved in emergency preparedness and infection control.

For questions about the content of this review or if you have received this and do not wish to receive these weekly notices, please e-mail us. If you have information that is pertinent to this notification process, please send it to us to be included in the routine report.

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## Table: Text-based Syndrome Case Definitions and Associated Category A Conditions

| Syndrome | Definition | Category A Condition |
|---|---|---|
| Botulism-like | ACUTE condition that may represent exposure to botulinum toxin<br>ACUTE paralytic conditions consistent with botulism: cranial nerve VI (lateral rectus) palsy, ptosis, dilated pupils, decreased gag reflex, media rectus palsy.<br>ACUTE descending motor paralysis (including muscles of respiration)<br>ACUTE symptoms consistent with botulism: diplopia, dry mouth, dysphagia, difficulty focusing to a near point. | Botulism |
| Hemorrhagic Illness | SPECIFIC diagnosis of any virus that causes viral hemorrhagic fever (VHF): yellow fever, dengue, Rift Valley fever, Crimean-Congo HF, Kyasanur Forest disease, Omsk HF, Hantaan, Junin, Machupo, Lassa, Marburg, Ebola<br>ACUTE condition with multiple organ involvement that may be consistent with exposure to any virus that causes VHF<br>ACUTE blood abnormalities consistent with VHF: leukopenia, neutropenia, thrombocytopenia, decreased clotting factors, albuminuria | VHF |
| Lymphadenitis | ACUTE regional lymph node swelling and/ or infection (painful bubo- particularly in groin, axilla or neck) | Plague (Bubonic) |
| Localized Cutaneous Lesion | SPECIFIC diagnosis of localized cutaneous lesion/ ulcer consistent with cutaneous anthrax or tularemia<br>ACUTE localized edema and/ or cutaneous lesion/ vesicle, ulcer, eschar that may be consistent with cutaneous anthrax or tularemia<br>INCLUDES insect bites<br>EXCLUDES any lesion disseminated over the body or generalized rash<br>EXCLUDES diabetic ulcer and ulcer associated with peripheral vascular disease | Anthrax (cutaneous)<br>Tularemia |
| Gastrointestinal | ACUTE infection of the upper and/ or lower gastrointestinal (GI) tract<br>SPECIFIC diagnosis of acute GI distress such as Salmonella gastroenteritis<br>ACUTE non-specific symptoms of GI distress such as nausea, vomiting, or diarrhea<br>EXCLUDES any chronic conditions such as inflammatory bowel syndrome | Anthrax (gastrointestinal) |

**Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents**
(continued from previous page)

| Syndrome | Definition | Category A Condition |
|---|---|---|
| Respiratory | ACUTE infection of the upper and/ or lower respiratory tract (from the oropharynx to the lungs, includes otitis media)<br>SPECIFIC diagnosis of acute respiratory tract infection (RTI) such as pneumonia due to parainfluenza virus<br>ACUTE non-specific diagnosis of RTI such as sinusitis, pharyngitis, laryngitis<br>ACUTE non-specific symptoms of RTI such as cough, stridor, shortness of breath, throat pain<br>EXCLUDES chronic conditions such as chronic bronchitis, asthma without acute exacerbation, chronic sinusitis, allergic conditions (Note: INCLUDE *acute exacerbation* of chronic illnesses.) | Anthrax (inhalational)<br>Tularemia<br>Plague (pneumonic) |
| Neurological | ACUTE neurological infection of the central nervous system (CNS)<br>SPECIFIC diagnosis of acute CNS infection such as pneumoccocal meningitis, viral encephailitis<br>ACUTE non-specific diagnosis of CNS infection such as meningitis not otherwise specified (NOS), encephailitis NOS, encephalopathy NOS<br>ACUTE non-specific symptoms of CNS infection such as meningismus, delerium<br>EXCLUDES any chronic, hereditary or degenerative conditions of the CNS such as obstructive hydrocephalus, Parkinson's, Alzheimer's | Not applicable |
| Rash | ACUTE condition that may present as consistent with smallpox (macules, papules, vesicles predominantly of face/arms/legs)<br>SPECIFIC diagnosis of acute rash such as chicken pox in person > XX years of age (base age cut-off on data interpretation) or smallpox<br>ACUTE non-specific diagnosis of rash compatible with infectious disease, such as viral exanthem<br>EXCLUDES allergic or inflammatory skin conditions such as contact or seborrheaic dermatitis, rosacea<br>EXCLUDES rash NOS, rash due to poison ivy, sunburn, and eczema | Smallpox |
| Specific Infection | ACUTE infection of known cause not covered in other syndrome groups, usually has more generalized symptoms (i.e., not just respiratory or gastrointestinal)<br>INCLUDES septicemia from known bacteria<br>INCLUDES other febrile illnesses such as scarlet fever | Not applicable |

**Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents** (continued from previous page)

| Syndrome | Definition | Category A Condition |
|---|---|---|
| Fever | ACUTE potentially febrile illness of origin not specified<br>INCLUDES fever and septicemia not otherwise specified<br>INCLUDES unspecified viral illness even though unknown if fever is present<br>EXCLUDE entry in this syndrome category if more specific diagnostic code is present allowing same patient visit to be categorized as respiratory, neurological or gastrointestinal illness syndrome | Not applicable |
| Severe Illness or Death potentially due to infectious disease | ACUTE onset of shock or coma from potentially infectious causes<br>EXCLUDES shock from trauma<br>INCLUDES SUDDEN death, death in emergency room, intrauterine deaths, fetal death, spontaneous abortion, and still births<br>EXCLUDES induced fetal abortions, deaths of unknown cause, and unattended deaths | Not applicable |